

		FOR OFF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0012328</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>												
<b>Facility Name:</b> <u>Apostolic Christian Home of Eureka</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.												
<b>Address:</b> <u>610 West Cruger</u> <u>Eureka</u> <u>61530</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.												
<b>County:</b> <u>Woodford</u>														
<b>Telephone Number:</b> <u>(309) 467-2311</u> <b>Fax #</b> <u>(309) 467-2584</u>														
<b>IDPA ID Number:</b> <u>37-6036029001</u>														
<b>Date of Initial License for Current Owners:</b> <u>2/16/1966</u>														
<b>Type of Ownership:</b>														
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT														
<input checked="" type="checkbox"/> Charitable Corp.														
<input type="checkbox"/> Trust														
<b>IRS Exemption Code</b> <u>501c(3)</u>														
<input type="checkbox"/> PROPRIETARY														
<input type="checkbox"/> Individual														
<input type="checkbox"/> Partnership														
<input type="checkbox"/> Corporation														
<input type="checkbox"/> "Sub-S" Corp.														
<input type="checkbox"/> Limited Liability Co.														
<input type="checkbox"/> Trust														
<input type="checkbox"/> Other														
<input type="checkbox"/> GOVERNMENTAL														
<input type="checkbox"/> State														
<input type="checkbox"/> County														
<input type="checkbox"/> Other														
In the event there are further questions about this report, please contact: <b>Name:</b> <u>Thomas A. Hoffman</u> <b>Telephone Number:</b> <u>(309) 467-2311</u>		<table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Thomas A. Hoffman</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td>(Telephone) _____ Fax # _____</td> </tr> <tr> <td colspan="2">           MAIL TO: BUREAU OF HEALTH FINANCE            ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES            201 S. Grand Avenue East            Springfield, IL 62763-0001 Phone # (217) 782-1630         </td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Thomas A. Hoffman</u>	Paid Preparer	(Title) <u>Administrator</u>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) _____ Fax # _____	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Officer or Administrator of Provider	(Signed) _____ (Date) _____													
	(Type or Print Name) <u>Thomas A. Hoffman</u>													
Paid Preparer	(Title) <u>Administrator</u>													
	(Signed) _____ (Date) _____													
	(Print Name and Title) _____													
	(Firm Name & Address) _____													
	(Telephone) _____ Fax # _____													
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630														

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>38</u>	Intermediate (ICF)	<u>38</u>	<u>13,870</u>	3
4		Intermediate/DD			4
5	<u>10</u>	Sheltered Care (SC)	<u>10</u>	<u>3,650</u>	5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,617</u>	<u>17,169</u>	<u>1,292</u>	<u>25,078</u>	8
9	SNF/PED					9
10	ICF	<u>1,572</u>	<u>11,574</u>		<u>13,146</u>	10
11	ICF/DD					11
12	SC		<u>3,018</u>		<u>3,018</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,189</u>	<u>31,761</u>	<u>1,292</u>	<u>41,242</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 94.95%D. How many bed-hold days during this year were paid by the Department?  
\_\_\_\_\_  
(Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Apartment, Duplex, CondominiumF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 16-Feb-66

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 16-Feb-66 NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 36 and days of care provided 1,292Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number      Apostolic Christian Home of Eureka      #      0012328      Report Period Beginning:      01/01/2005      Ending:      12/31/2005

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	308,677	19,262	13,714	341,653		341,653		341,653			1
2	Food Purchase		234,718		234,718		234,718	(9,670)	225,048			2
3	Housekeeping	133,743	21,647	921	156,311		156,311	(4,000)	152,311			3
4	Laundry	125,548	13,510	1,586	140,644		140,644		140,644			4
5	Heat and Other Utilities			221,258	221,258		221,258	(38,195)	183,063			5
6	Maintenance	144,178	12,085	46,615	202,878		202,878	(23,260)	179,618			6
7	Other (specify):*											7
8	TOTAL General Services	712,146	301,222	284,094	1,297,462		1,297,462	(75,125)	1,222,337			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100		2,100			9
10	Nursing and Medical Records	2,450,355	34,814	329,251	2,814,420	52,310	2,866,730	(3,383)	2,863,347			10
10a	Therapy	55,322	1,006	110,310	166,638		166,638	6,383	173,021			10a
11	Activities	168,036	7,775	6,254	182,065		182,065	(828)	181,237			11
12	Social Services	48,955	54	3,894	52,903		52,903		52,903			12
13	CNA Training					9,401	9,401	(1,200)	8,201			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,722,668	43,649	451,809	3,218,126	61,711	3,279,837	972	3,280,809			16
	C. General Administration											
17	Administrative	153,383			153,383		153,383	(19,780)	133,603			17
18	Directors Fees											18
19	Professional Services			7,574	7,574		7,574		7,574			19
20	Dues, Fees, Subscriptions & Promotions			33,244	33,244		33,244	(424)	32,820			20
21	Clerical & General Office Expenses	110,627	8,329	52,970	171,926	(1,972)	169,954	(16,149)	153,805			21
22	Employee Benefits & Payroll Taxes			774,855	774,855		774,855	(8,776)	766,079			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,567	9,567	(1,300)	8,267	(642)	7,625			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			137,274	137,274		137,274	(24,637)	112,637			26
27	Other (specify):*											27
28	TOTAL General Administration	264,010	8,329	1,015,484	1,287,823	(3,272)	1,284,551	(70,408)	1,214,143			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,698,824	353,200	1,751,387	5,803,411	58,439	5,861,850	(144,562)	5,717,289			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number      Apostolic Christian Home of Eureka      #0012328      Report Period Beginning:      01/01/2005      Ending:      12/31/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			347,346	347,346		347,346	(79,551)	267,795			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			11,888	11,888		11,888	(11,888)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					1,972	1,972		1,972			35
36	Other (specify):*											36
37	TOTAL Ownership			359,234	359,234	1,972	361,206	(91,439)	269,767			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		136,497	5,925	142,422	(60,411)	82,011		82,011			39
40	Barber and Beauty Shops			25,771	25,771		25,771		25,771			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678		59,678		59,678			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		136,497	91,374	227,871	(60,411)	167,460		167,460			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,698,824	489,697	2,201,995	6,390,516		6,390,516	(236,001)	6,154,516			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

## STATE OF ILLINOIS

Page 5

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(9,670)	2.2	4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation	1,574	30.3	9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds		2.2	11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax			13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional	(349)	20.3	25
	Income Taxes and Illinois Personal			
26	Property Replacement Tax			26
27	CNA Training for Non-Employees			27
28	Yellow Page Advertising		20.3	28
29	Other-Attach Schedule	(227,556)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (236,001)		30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)		34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (236,001)	37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38		x	\$		38
39		x			39
40		x			40
41		x			41
42		x			42
43		x			43
44		x			44
45		x			45
46		x			46
47			\$		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$ -			\$ -		1
2	V			-			-		2
3	V			-			-		3
4	V			-			-		4
5	V			-			-		5
6	V			-			-		6
7	V			-			-		7
8	V			-			-		8
9	V			-			-		9
10	V			-			-		10
11	V			-			-		11
12	V			-			-		12
13	V			-			-		13
14	Total			\$			\$	*	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	8		
	2001	9		
	2002	10		
	2003	11		
	2004	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

### 2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Home of Eureka COUNTY Woodford  
 FACILITY IDPH LICENSE NUMBER 0012328  
 CONTACT PERSON REGARDING THIS REPORT Thomas A. Hoffman  
 TELEPHONE (309) 467-2311 FAX #: (309) 467-2584

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,865 B. General Construction Type: Exterior Brick Frame Protected Ord. & Fire Resista Number of Stories One

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Nursing Home</u>	<u>63,500</u>	<u>1963</u>	<u>\$ 58,945</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>63,500</u>		<u>\$ 58,945</u>	<u>3</u>

Facility Name &amp; ID Number    Apostolic Christian Home of Eureka

#    0012328

Report Period Beginning:

01/01/2005    Ending:    12/31/2005

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		1966	1966	\$ 488,404	\$ 12,192	40	\$ 12,193	\$ 1	\$ 488,404	4
5	38		1975	1975	605,234	15,091	40	15,131	40	447,462	5
6	11		1994	1994	1,522,126	38,053	39	39,029	976	443,006	6
7	8		1994	1994	226,582	6,632	39	5,810	(822)	64,000	7
8				1989	3,512	176	20	176		2,904	8
	Improvement Type**										
9				1967	17,605	440	40	440		17,136	9
10				1968	1,508		20			1,508	10
11				1969	11,406		20			11,406	11
12				1970	8,431		20			8,431	12
13				1971	2,975		20			2,975	13
14				1972	550		5			550	14
15				1977	38,346		20			38,346	15
16				1979	1,260		5			1,260	16
17				1981	4,140		10			4,140	17
18				1982	15,776	770	20		(770)	15,776	18
19				1983	4,826		10			4,826	19
20				1984	8,271		10			8,271	20
21				1985	15,630		20			15,630	21
22				1986	8,500		10			8,500	22
23				1987	950		19	50	50	950	23
24				1988	69,201	3,460	20	3,460		62,280	24
25	Kitchen Addition			1989	12,677	634	20	634		10,461	25
26	Bldg Improvement			1989	10,281		10			10,281	26
27	Water Heater			1990	2,272		20	114	114	1,805	27
28	Central Air			1990	3,978		10			3,978	28
29	Improve Door			1990	2,235		10			2,235	29
30	Remodeling			1990	503	25	20	25		388	30
31	Sprinkler Heads			1990	1,504	75	20	75		1,175	31
32	Blacktopping			1990	3,000	150	20	150		2,375	32
33	Cubicle Curtain Track			1991	850	43	20	43		642	33
34	Carpeting/Woodwork			1991	795	40	20	40		596	34
35	Key Pads/Door System			1991	2,670	134	20	134		1,977	35
36	Thermo Mixing Valves			1991	3,310	166	20	166		2,442	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Air Conditioning Unit	1991	\$ 3,012	\$	10	\$	\$	\$ 3,012	37	
38	Wall Air Conditioning Unit	1991	910		10			910	38	
39	Patio	1991	2,150	108	20	108		1,575	39	
40	Asphalt Parking	1992	8,938	447	20	447		6,075	40	
41	Trees & Shrubs	1992	403	20	20	20		272	41	
42	Radiator Covers	1992	5,500	275	20	275		3,843	42	
43	Plumbing Upgrade	1992	2,348	117	20	117		1,634	43	
44	Shed	1992	2,000	100	20	100		1,356	44	
45	Alarm System	1992	4,520	226	20	226		3,052	45	
46	Lock Sets	1992	1,207	60	20	60		785	46	
47	Water Heater	1992	10,252		10			10,252	47	
48	Air Conditioner	1992	886		10			886	48	
49	Air Conditioner	1992	926		10			926	49	
50	Air Conditioner	1992	858		10			858	50	
51	Drapes and Rods	1992	1,057		10			1,057	51	
52	Fireplace Glass	1992	587		10			587	52	
53	Air Conditioner	1993	1,303		10			1,303	53	
54	Fountain Lights	1993	1,179		10			1,179	54	
55	Exterior Lighting	1993	850	42	20	43	1	550	55	
56	Hallway Remodeling	1993	2,383	119	20	119		1,511	56	
57	Kitchen Flooring	1993	2,441	122	20	122		1,531	57	
58	Office Addition	1994	57,234	1,431	39	1,468	37	17,129	58	
59	Roof	1994	17,577	879	20	879		9,888	59	
60	Interior Hallway	1994	7,134		10			7,134	60	
61									61	
62	Phone System	1994	13,120		10			13,120	62	
63	Air Conditioner	1995	1,158	58	10	41	(17)	1,158	63	
64	Drapes	1995	529	26	10	50	24	529	64	
65	Remodel	1995	5,366		5			5,366	65	
66	Improvements	1995	3,293	165	10	97	(68)	3,293	66	
67	Roof & Insulation	1995	21,002	1,050	20	1,050		11,029	67	
68	Building Improvements	1995	7,787	149	10	612	463	7,787	68	
69	Life Safety Code	1995	21,125	1,056	20	1,056		10,606	69	
70	TOTAL (lines 4 thru 69)		\$ 3,308,343	\$ 84,531		\$ 84,560	\$ 29	\$ 1,816,309	70	

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12B

Facility Name &amp; ID Number      Apostolic Christian Home of Eureka

#      0012328

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

**XI. OWNERSHIP COSTS (continued)**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 3,308,343	\$ 84,531		\$ 84,560	\$ 29	\$ 1,816,309		1
2	Air Conditioner	1996	485	49	10	49		484		2
3	Phone System-Social Service	1996	1,201	120	10	120		1,185		3
4	Air Conditioner	1996	2,886	289	10	289		2,770		4
5	Water Softner	1996	3,442	344	10	344		3,284		5
6	Social Service Office Remodel	1996	2,750	207	20	138	(69)	1,717		6
7	Life Safety Code	1996	8,113	336	20	406	70	3,669		7
8	Life Safety Door	1996	5,061	253	20	253		2,479		8
9	Front Room Wallpaper	1996	1,008	101	10	101		976		9
10	Ventilation & A/C System	1996	5,990	599	10	599		5,744		10
11	Front Room Carpet	1996	2,432	122	20	122		1,169		11
12	Guttering System	1996	3,355	168	20	168		1,603		12
13	Air Conditioning	1996	9,314	466	20	466		4,448		13
14	Air Conditioning	1996	1,008	50	20	50		469		14
15	Cabinetry in Tub Room	1996	2,945	295	10	295		2,741		15
16	Air Conditioning & Ventilation System	1996	8,942	447	20	447		4,154		16
17	Speaker System	1996	3,798	380	10	380		3,500		17
18	Life Safety Ventilation System	1996	798	40	20	40		368		18
19	Six Air Conditioners	1997	2,882	288	10	288		2,546		19
20	Water Heater	1997	5,871	587	10	587		5,040		20
21	Wall Fountain	1997	653	65	10	65		531		21
22	Draperys	1997	2,839	284	10	284		2,319		22
23	Smoke Detectors	1997	3,103	310	10	310		2,764		23
24	Carpeting	1997	3,525	176	20	176		1,437		24
25	Hall Remodeling	1997	16,641	832	20	832		6,795		25
26	Five Air Conditioners	1998	2,447	245	10	245		1,907		26
27	Water Heater	1998	2,940	294	10	294		2,122		27
28	Air Conditioner	1998	5,415	542	10	542		3,840		28
29	Room Door Guards	1999	2,139	214	10	214		1,454		29
30	Door Alarm Keypads	1999	2,293	229	10	229		1,481		30
31	Seven Air Conditioners	1999	3,182	318	10	318		2,199		31
32	Kitchen Shelving Units	1999	2,838	283	10	284	1	1,875		32
33	Three Air Conditioners	1999	1,425	143	10	143		911		33
34	TOTAL (lines 1 thru 33)		\$ 3,430,064	\$ 93,607		\$ 93,638	\$ 31	\$ 1,894,290		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12C

Facility Name &amp; ID Number      Apostolic Christian Home of Eureka

#      0012328

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

**XI. OWNERSHIP COSTS (continued)**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,430,064	\$ 93,607		\$ 93,638	\$ 31	\$ 1,894,290	1
2	Room Door Guards	1999	2,610	261	10	261		1,579	2
3	Seven Air Conditioners	2000	3,626	363	10	363		2,148	3
4	Air Conditioner	2000	1,508	151	10	151		799	4
5	Generator & Building	2000	303,143	7,579	40	7,579		44,851	5
6	Wall Carpet	2000	3,630	363	10	363		2,178	6
7	Carpeting	2000	21,956	2,196	10	2,196		12,634	7
8	Courtyard Improvements	2000	5,312	306	10	531	225	2,655	8
9	Courtyard improvements	1999	11,738	1,444	10	1,174	(270)	6,896	9
10	Air conditioner	2001	632	63	10	63		292	10
11	Lighting	2001	2,233	447	5	447		1,995	11
12	Attached wash stations	2001	849	85	10	85		372	12
13	Hot water heater	2001	939	188	5	188		792	13
14	Counter top	2001	550	55	10	55		225	14
15	Air conditioner	2001	9,725	486	20	486		2,146	15
16	Installation of sinks	2001	1,050	105	10	105		451	16
17	New dumpster door	2002	928	46	20	46		173	17
18	Flooring for 2002 addition and remodel	2002	85,333	4,267	20	4,267		12,801	18
19	2002 addition and remodel	2002	2,247,842	56,196	40	56,196		168,588	19
20	Room designation	2002	627	63	10	63		244	20
21	Water heater	2002	4,147	415	10	415		1,593	21
22	Drapes and blinds for dining, activity, therapy	2002	15,437	1,544	10	1,544		4,632	22
23	Courtyard sprinkler system	2002	8,800	880	10	880		3,154	23
24	Gravel driveway	2002	634	127	5	127		455	24
25	Landscaping for 2002 addition	2002	198,700	9,935	20	9,935		29,805	25
26	Sprinkler system for 2002 addition	2002	9,600	960	10	960		2,880	26
27	Surveillance camera	2003	1,750	350	5	350		993	27
28	Water heater	2003	4,965	496	10	497	1	1,410	28
29	Signage	2003	895	90	10	90		255	29
30	Valances	2003	662	66	10	66		182	30
31	Electrical work addition	2003	8,185	205	40	205		582	31
32	Addition painting	2003	5,289	132	40	132		364	32
33	Remodel breakroom	2003	3,085	154	20	154		424	33
34	TOTAL (lines 1 thru 33)		\$ 6,396,444	\$ 183,625		\$ 183,612	\$ (13)	\$ 2,202,838	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12D

Facility Name &amp; ID Number Apostolic Christian Home of Eureka

# 0012328

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,396,444	\$ 183,625		\$ 183,612	\$ (13)	\$ 2,202,838	1
2	Thermostats in addition	2003	560	56	10	56		140	2
3	Steel Doors	2003	1,095	55	20	55		133	3
4	Oxygen room exhaust fan	2003	2,062	52	40	52		121	4
5	Storm sewer work	2003	3,500	350	10	350		847	5
6	Door alert system	2004	1,342	134	10	134		257	6
7	Hot water heater	2004	2,977	298	10	298		323	7
8	Smoke detectors, roller latches, fire window	2004	8,913	797	13	686	(111)	1,315	8
9	Life safety, wall repair, carpeting	2004	9,202	633	15	613	(20)	1,127	9
10	Handrails	2004	1,472	147	10	147		258	10
11	Roofing	2004	6,500	325	20	325		516	11
12	Remodel tubroom, room 121 & 123, hallways	2004	47,702	2,385	20	2,385		3,587	12
13	Carpeting room 255-257, office renovations	2004	13,647	683	20	682	(1)	740	13
14	Carpeting rm 251-254 & 258-259, heating & panic door	2004	8,348	485	17	491	6	491	14
15	Water softner for kitchen	2005	3,708	185	10	249	64	249	15
16	Cabinet for dining	2005	719	36	10	36		36	16
17	ADON office remodel	2005	1,841	46	20	77	31	77	17
18	Living room remodel	2005	1,615	40	20	68	28	68	18
19	Door for laundry room	2005	536	13	20	20	7	20	19
20	Water lines for water softner	2005	780	20	20	23	3	23	20
21	Central air conditioning unit	2005	4,902	123	20	124	1	124	21
22	Remodel tub rooms	2005	47,940	1,199	20	1,005	(194)	1,005	22
23	Kitchen hood and light fixtures	2005	9,076	227	20	152	(75)	152	23
24	Replace floor in walk-in cooler	2005	2,160	54	20	27	(27)	27	24
25	Doors for east hall room	2005	1,280	32	20	5	(27)	5	25
26	Wall carpet and corner guards	2005	2,278	88	15	13	(75)	13	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,580,599	\$ 192,088		\$ 191,685	\$ (403)	\$ 2,214,492	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 13

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 426,149	\$ 54,852	\$ 54,852	\$	10	\$ 137,301	71
72	Current Year Purchases	142,596	12,267	12,267		10	12,267	72
73	Fully Depreciated Assets	901,826					901,826	73
74								74
75	TOTALS	\$ 1,470,571	\$ 67,119	\$ 67,119	\$		\$ 1,051,394	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	91 Chevy van, 99 Ford bus	1992 & 1999	\$ 73,703	\$ 4,924	\$ 4,924	\$	10	\$ 56,868	76
77	Maintenance	86 Chevy Pickup	1996	8,159	1,145	816	(329)	10	6,323	77
78	Maintenance	98 Dodge Truck	1999	13,280	1,328	1,328		10	9,172	78
79	Patient Transport	05 Chevy bus	2005	46,122	2,306	4,612	2,306	10	4,612	79
80	TOTALS			\$ 141,264	\$ 9,703	\$ 11,680	\$ 1,977		\$ 76,975	80

## E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,251,379 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 268,910 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 270,484 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,574 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,342,861 85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments	\$ 372,371	\$ 11,421	\$ 349,141	86
87	Condos	1,399,761	36,468	555,564	87
88	Duplexes	916,465	30,548	657,360	88
89	Rental Units	454,138			89
90	Land	236,950			90
91	TOTALS	\$ 3,379,685	\$ 78,437	\$ 1,562,065	91

## G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 45,333	92
93			93
94			94
95		\$ 45,333	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2006 \$ \_\_\_\_\_

13. \_\_\_\_\_/2007 \$ \_\_\_\_\_

14. \_\_\_\_\_/2008 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☒ NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

16. Rental Amount for movable equipment: \$ 1,972 Description: Copy machines

☐ YES ☒ NO

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number      Apostolic Christian Home of Eureka      #      0012328      Report Period Beginning:      01/01/2005      Ending:      12/31/2005

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>40</u>
		HOURS PER CNA <u>80</u>	

**B. EXPENSES**

**ALLOCATION OF COSTS** (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		4,217		4,217
5	In-House Trainer Wages (c)		3,168		3,168
6	Transportation				
7	Contractual Payments			1,200	1,200
8	CNA Competency Tests		816		816
9	TOTALS	\$	\$ 8,201	\$ 1,200	\$ 9,401
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,201		

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ 600

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>	
1. From this facility	4
2. From other facilities (f)	1
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	10a.3	hrs	\$	
2	Licensed Speech and Language Development Therapist	10a.3	hrs		56	3,454		56	3,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		219	18,346		219	18,346	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				54,858		54,858	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify):    Medical Supplies	39.2					27,153		27,153	13
14	TOTAL			\$	505	\$ 39,452	\$ 82,011	505	\$ 121,463	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number      Apostolic Christian Home of Eureka

#      0012328

Report Period Beginning:      01/01/2005

Ending:      12/31/2005

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of      12/31/2005      (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,249,317	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	344,794		3
4	Supply Inventory (priced at FIFO )	38,851		4
5	Short-Term Investments			5
6	Prepaid Insurance	90,096		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,723,058	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	754,625		13
14	Buildings, at Historical Cost	8,928,408		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,897,571		16
17	Accumulated Depreciation (book methods)	(4,955,331)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Process	45,333		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,670,606	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,393,664	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (101,430)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(290,253)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(712)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(21,318)		36
37	Life Lease Deferred Income	(192,768)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (606,481)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Lease Equity	(1,915,926)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (1,915,926)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,522,407)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,871,257)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (8,393,664)	\$	48

\*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,671,547	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,671,547	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,710	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 199,710	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,871,257	24 *

\* This must agree with page 17, line 47.

## STATE OF ILLINOIS

Page 19

Facility Name & ID Number Apostolic Christian Home of Eureka# 0012328Report Period Beginning: 01/01/2005Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,919,559	1
2	Discounts and Allowances for all Levels	(440,101)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,479,458	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	209,824	6
7	Oxygen	21,173	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 230,997	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	25,795	13
14	Non-Patient Meals	12,725	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,343	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,655	19
20	Radiology and X-Ray		20
21	Other Medical Services	125,718	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 257,236	23
D. Non-Operating Revenue			
24	Contributions	326,668	24
25	Interest and Other Investment Income***	40,322	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 366,990	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	9,315	28
28a	Non-Care Facility	246,230	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 255,545	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,590,226	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	1,297,462	31
32	Health Care	3,218,126	32
33	General Administration	1,287,823	33
B. Capital Expense			
34	Ownership	359,234	34
C. Ancillary Expense			
35	Special Cost Centers	168,193	35
36	Provider Participation Fee	59,678	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,390,516	40
41	Income before Income Taxes (line 30 minus line 40)**	199,710	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,710	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 61,996	\$ 29.81	1
2	Assistant Director of Nursing	2,080	2,080	49,494	23.80	2
3	Registered Nurses	19,023	20,397	524,197	25.70	3
4	Licensed Practical Nurses	19,342	21,300	419,921	19.71	4
5	CNAs & Orderlies	98,480	107,129	1,387,362	12.95	5
6	CNA Trainees	484	484	4,217	8.71	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,751	4,122	55,322	13.42	8
9	Activity Director	1,633	1,809	24,752	13.68	9
10	Activity Assistants	14,812	16,079	143,284	8.91	10
11	Social Service Workers	3,193	3,227	48,955	15.17	11
12	Dietician					12
13	Food Service Supervisor	3,473	3,534	55,064	15.58	13
14	Head Cook	5,760	6,271	60,348	9.62	14
15	Cook Helpers/Assistants	10,189	10,982	99,123	9.03	15
16	Dishwashers	10,607	11,340	94,142	8.30	16
17	Maintenance Workers	7,309	7,878	134,505	17.07	17
18	Housekeepers	13,644	15,036	129,959	8.64	18
19	Laundry	12,145	13,247	125,548	9.48	19
20	Administrator	1,812	1,812	80,631	44.50	20
21	Assistant Administrator					21
22	Other Administrative	10,544	11,401	84,185	7.38	22
23	Office Manager	1,812	1,812	52,973	29.23	23
24	Clerical	1,564	1,801	13,729	7.62	24
25	Vocational Instruction	132	132	3,168	24.00	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	243,869	263,953	\$ 3,652,875 *	\$ 13.84	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	149	\$ 7,234	1.3	35
36	Medical Director	12	2,100	9.3	36
37	Medical Records Consultant	24	1,440	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,120	10.3	39
40	Physical Therapy Consultant	5	238	10a.3	40
41	Occupational Therapy Consultant	72	4,252	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	684	10a.3	43
44	Activity Consultant	37	2,090	11.3	44
45	Social Service Consultant	66	3,686	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	413	\$ 24,844		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	299	\$ 9,701	10.3	50
51	Licensed Practical Nurses	3,962	133,887	10.3	51
52	Certified Nurse Assistants/Aides	8,645	159,069	10.3	52
53	TOTAL (lines 50 - 52)	12,906	\$ 302,657		53





Facility Name &amp; ID Number    Apostolic Christian Home of Eureka

#    0012328

Report Period Beginning:    01/01/2005

Ending:    12/31/2005

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network Dues 6,808
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 6.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,486 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,678  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,670
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.